DOCUMENT RESUME

ED 065 426 24 SO 004 017

AUTHOR Treuting, W. L.; And Others
TITLE University-Urban Interface Program. Background Paper: The University and the Community in the Domain of Health.
INSTITUTION Pittsburgh Univ., Pa.
SPONS AGENCY Office of Education (DHEW), Washington, D.C. Bureau of Research.
BUREAU NO BR-8-0725
PUB DATE Dec 71
GRANT OEG-2-9-480725-1027
NOTE 49p.

EDRS PRICE MF-$0.65 HC-$3.29
DESCRIPTORS Community Cooperation; Community Health; *Community Relations; *Conflict Resolution; *Health Services; *Interagency Cooperation; Local Issues; Role Perception; Social Problems; *Urban Universities
IDENTIFIERS Pittsburgh

ABSTRACT

The first part of the paper focuses on concepts and ideas which can be used to discuss interface in any field or domain. For example, meaning of words "community" and "university" are sorted out. Attention is given to the idea of interface as expectations, goals, attitudes, purposes and behavior. In the second part, these same concepts are re-examined in the domain of medical and health services in a community with a university medical facility. Many issues are raised but no stand is taken. The paper is designed to stimulate thinking about what an individual in the "university" or in the "community" might do in reaching an interface. (Related documents are SO 004 018 and SO 004 019.) (Author/VLW)

ED 065426

BR 80725
PA24 BHE

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UNIVERSITY FORUM

BACKGROUND PAPER

THE UNIVERSITY AND THE COMMUNITY IN THE DOMAIN OF HEALTH

DECEMBER 9, 1971

UNIVERSITY-URBAN INTERFACE PROGRAM

CONTRACT NO. OEG-2-9-480725-1027
PROJECT NO. 80725

SP 004 017

SUBMITTED TO THE
BUREAU OF RESEARCH U.S.O.E.

OFFICE OF THE SECRETARY
UNIVERSITY OF PITTSBURGH
DECEMBER, 1971

ED 065426

UNIVERSITY-URBAN INTERFACE PROGRAM

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BACKGROUND PAPER

THE UNIVERSITY AND THE COMMUNITY IN THE DOMAIN OF HEALTH

DECEMBER, 1971

W. L. Treuting, M.D., M.P.H.
Professor, Department Chairman, Public Health Practice

W. T. Hall, M.S.W., Ph.D.
Professor, Public Health Social Work, Graduate School of Public Health
Professor, Graduate School of Social Work

M. L. Baizerman, M.S.W., M.Sc.
Senior Research Associate , Maternal & Child Health

Albert C. Van Dusen, Ph.D.
Secretary of the University
Principal Investigator

Robert C. Brictson, Ph.D.
Director of Research Programs

OVERVIEW

I. PURPOSE

The attached paper presents concepts and ideas about what an Interface is in the domain of medical and health services and how it can be created and sustained. Our purpose is to stimulate your thinking about what you the participant might want to say or do.

The paper is in two main parts. On the first part, focus is on concepts and ideas which can be used to discuss Interface in any field or domain. For example, emphasis is on sorting-out several meanings of the words "community" and "university". Attention is given to the idea of Interface as expectations, goals, attitudes, purposes and behavior. In the second part, these same concepts are re-examined in the domain of medical and health services.

There are few concrete examples in the paper. Many issues are raised but no stand is taken on these. Our expectation is that you will exchange with other participants in the day long seminar examples, ideas, concepts and other issues which in your judgement are critical for the examination and creation of an Interface in the domain of medical and health services.

II. SOME ISSUES AND QUESTIONS

As another means of stimulating your thinking about what you might say or do, several issues and many questions are presented now.

1. One can conceive of many Interfaces where interaction occurs between individuals who live in the community and individuals who work for the university. An individual could be a patient in a university-medical clinic or a consumer of services provided by a clinic, a prospective employee, a student, etc.

On another level, one can conceive of groups of people, agencies and organizations in the community which interact with the university on issues or problems of mutual concern.

Taken together, there are many boundary points between university and community. At places, these boundaries are very vague; at other points, the boundary is quite clear. There are several specific and several vague boundaries in the domain of medical and health services.

2. Many in the university do not "understand the community" and many in the community do not "understand the university." Effort must be made to demystify the University and the Community.

3. Many in the community and in the university may hold unclear or unstated expectations of each other. In addition, there may be differences in goals, attitudes, purposes and style between individuals, groups, agencies in the community. There, differences can be seen at the boundary between University and Community in the domain of medical and health services.

4. Some foci for discussion of medical and health services might be the following topics:

---the availability and accessibility of medical and health services
---what determines whether services will be offered
---who receives these services; who does not -, who might want to receive these
---who pays for these services; who should pay
---who is accountable for the effectiveness, efficiency, availability, accessibility of these services
---who decides what services should or will be offered, where, when, how, by whom, at what cost

5. Some questions:

(A) When I use the word "community", who or what do I have in mind?

(B) When I use the word "university", what do I have in mind?

(C) What groups or agency or organizations do I feel I represent?

(D) What are my expectations about this meeting?

(E) What do I (or my group, etc.) expect other groups or organizations to say about medical and health services; and to do about what they say?

(F) Do I believe that what I or my group say today will have any effect on what other people or groups or agencies or the university will do?

(G) I think that the most important barrier to the Interface between the university and or my group is....

THE UNIVERSITY AND THE COMMUNITY: THE SEARCH FOR AN INTERFACE IN THE DOMAIN OF HEALTH

INTRODUCTION

The interface between the University and the Community is elusive. This is so, in part, because each seems to believe that the other does not fully "understand" it, and, consequently, makes of it unfair and unreasonable demands. Our task is to facilitate the creation - or re-creation - of this much needed interface in the domain of health. The chosen approach is to suggest some issues which to us belong at the interface. In this paper, one view will be placed against another. Your task is to find what is acceptable in each. It is with this understanding and acceptance that an interface can be created by you. As a paper to stimulate discussion, ideas and issues, not solutions, are presented.

I. THE ELEMENTS: INTRODUCTION & DEFINITION

A. THE INTERFACE

To facilitate the search for an interface, a tentative definition of it is suggested:

> An interface is those expectations of behavior held in common by those in the University and those outside of it on what each can offer the other and on how they can "work together." Second, the interface is the process of working together; third, it is the relationship which results from joint effort. At minimum, this relationship allows for and suggests open, on-going, joint discussion and evaluation.

The word interface as defined here includes shared expectations and beliefs on the value of joint action, the means of achieving this sharing and the acts themselves.

The interface which you hope to achieve is in part emotion, in part cognition and in part behavior. Clearly, emotion, cognition and behavior are attributes of people, not of organizations. How, then, can this definition of interface prove useful?

The definition of interface will be useful if a distinction is made between the University as a corporate entity and the University as its members -- faculty, staff and students. Similarly, there is a distinction between the word Community as an abstract term and the word community when it is used to mean people living in a certain place. We ask that you keep these distinctions before you. Both of the central words - university and community -- refer to things, to people, to ideas. It is imperative that the particular meaning you give to university or community be specified. Without such specification, the Interface will be even more difficult to achieve.

In order to make clear these distinctions, some examples are given.

B. THE UNIVERSITY AS A THING AND AS PEOPLE

A distinction is made between the University as a corporate entity and as the sum of the people and buildings which comprise it. In the first instance, the University is a legal "person" with certain rights and responsibilities. It is "more than" the sum of the people and the buildings which comprise it. In everyday discussion, this legal conception loses its specific, technical meaning, and people argue about the "role of the University", its mission, how "it" is governed.

The other meaning of the word university focuses on the people, equipment and physical plant. This is the University one "sees" when he goes to a campus or attends a class. Since the same word, university, means both the corporate entity and the people and buildings, it is often

difficult to discuss the Interface between the University and the Community. The person speaking and the person listening could have different conceptions of the university in mind. These different conceptions of the term university contribute to forming a barrier to the development of the interface.

C. THE COMMUNITY: SEVERAL MEANINGS

The word community also has many meanings. First, community means place, a geographic area larger than a neighborhood. Second, community means existing voluntary associations like ethnic and racial groups or other associations of people who join in common effort for pleasure, gain, identification, etc. Third, community means those people who live in a given geographic area - whether or not they belong to voluntary associations. Last, community means an ideology, a social philosophy, a goal to achieve. This last meaning implies a commonality among people, a binding belief or awareness which gives each person a sense of belonging.

Taken together, these four categories are not inclusive of all the meanings of the word community. They do suggest, however, that the word means different things and its meaning for a particular purpose must be specified. Without such specification the interface will continue to be elusive.

D. THE COMMUNITY: SOME FURTHER DEFINITIONS

The concept community has come to mean something else recently. It is used often as synonymous to poor people, specifically the "minority" poor - the Blacks, Chicanos, Puerto Ricans and "ethnic whites" like "the Poles." This meaning is so persuasive that many assume that a discussion

of the interface between the University and the Community will be centered on the relations between poor people e.g., poor Blacks and the University. Poor people are only some of those who live in a given community.

Some order is brought to these different meanings of community as place, people, social groups and ideology by distinguishing between the organized groups, business, etc., in the community - the organized community - and the people in a community. i.e., the unorganized community. The unorganized community refers to the people as a logical class - i.e. unspecified people living in a specified geographic area.

II. TOWARD THE INTERFACE: PERCEPTIONS AND EXPECTATIONS

Basic to effective and acceptable joint action is an understanding, if not acceptance, of the perceptions and expectations that one party or group has of the other. When perceptions are inaccurate, it is difficult for expectations to be communicated effectively and to be met. When expectations are not met, we see the consequences in un-intended conflict, personal anger, etc.

The purpose of the following discussions is to make explicit some of the perceptions and expectations held of each other by many in the university and in the community

A. VIEWS OF THE COMMUNITY HELD BY MANY IN THE UNIVERSITY

One view held by many in the university is that the Community is an underdeveloped or, a developing area. This might be called the "foreign affairs" view. Implicit in this view is a definition of community as poor, minority-group people living in "slums" which are "disorganized" and "pathological". This meaning of community can be summarized as the "them" definition.

In the foreign affairs view, is a colonial view. Those who hold these views, and few do so publicly anymore, see and emphasise the

"bad", the "sick", the dysfunctional or the pathologic in the community. Many who look at the community through the glasses of the foreign affairs model feel fear and anger. They see poverty. To them, poverty means "being poor, being powerless, being despised and being incompetent." This view of the community is not a pretty one. Yet it is real, and thus, it is a barrier to an interface.

A second view held by many in the University is that the community is a laboratory for teaching, research and service. From this perspective, community means place and people. It is a "natural laboratory", indeed, a necessary one, in which one can do research and learn, can "develop knowledge." It is a place to send students in order to expose them to the "real world." Increasingly, it is a place where students ask to be sent to "organize" and to give other services to low-income, ethnic and racial groups.

A third view of community is held by many in the fields of public health and community medicine: The community as the patient. We return to this view later.

Last, many think only about the "organized community" - the small business, corporations, and voluntary associations - when considering the relation between the University (or their program) and the Community. For many, it is easier to think about the organized community than the unorganized community. Those who are organized are easily identified. Their organization has form and structure; often, it has a telephone, a letterhead, an address. And most important, it has identified "leaders" - specific people to talk to.

These "leaders" are important in the foreign affairs model. With them, one can have "diplomatic relations", one can negotiate. How does one "reach" or talk to an unorganized community?

B. VIEWS OF THE UNIVERSITY HELD BY MANY IN THE COMMUNITY

One can distinguish three views of the University held by many in the community.

One view sees the University as an ivory tower. This view holds that the "real world" is in the community and the University is an "unreal world". In this unreal world are professors who have "theories" but little "real knowledge", people who are not "practical", who could not "survive on the outside" and thus they retreat to the ivory tower. At Pitt, the tower is clearly visible, if not ivory. From it, one can indeed "look down" on the community - pun intended!

A second view sees the University as a frontier post. This view holds that the University is a place of scholarship. To some, scholarship is the process of searching for "truth", to others, it is the process of searching for "answers". Searching for "truth" goes along with the ivory tower view of the University. Searching for "answers" can go along with the view of the University as a service station.

A third view of the University holds that it is a service station, a place where people think about answers to problems of concern to people in the community and then work with community people to try to solve these problems. In this view, the pursuit of "truth" and "answers" is of value only in so far as this knowledge is used directly and immediately for the benefit of people. The people who should have first priority for service are those in the communities near the University.

C. SUMMARY

We have discussed briefly some of the views of the Community held by many in the University and some of the views of the University held by many in the Community. Those who hold each of these views also hold expectations about how the people who comprise the University and the Community will think, will feel, will behave. Some of the expectations concern what problems people think exist in the community and what the Community and the University will do to solve these.

The views that people hold of each other and the expectations they have of each other determine in large part how people will behave towards each other, whether they will work together and whether a relationship between them will emerge. All of these together are the Interface. There may be little interface now between the University and the community because people hold different views of each other and different or unclear expectations of each other. By examining the word "problem", insight is gained on how different definitions of a word are related to different expectations of behavior. And how these different expectations of behavior can lead to confusion, to anger, to non-communication. Without communication, there can be no interface.

III. SOME CONSEQUENCES OF THE DIFFERENT VIEWS AND EXPECTATIONS

A. PROBLEMS: THEIR DEFINITION AND SOLUTION

Often implicit in University - Community relations are the beliefs that problems exist in the community, that the University is aware of these, that it is obligated to help solve these problems, and that it frequently chooses not to. This is the view of the University as a service station. It is also the University-extension model. This view and this model are built on the expectation of service or aid, and on a

commonly held belief that if the University would only accept the fact that there are problems in the Community, it would and could help solve these; that is, the University would offer service and a solution would follow. Imbedded in the word "problem" are several issues which contribute to a major disjointedness between the University and the Community. This disjointedness, in turn, is a result of the different meanings given to the word problem.

When a word used by people talking to one another is used differently by each, confusion results: People talk past one another, and thus they can't get together.

What is a social problem and how does it "come to be?" We suggest that social problems do not exist "out there", somewhere, waiting to be discovered. Instead, these problems are "man made", they are brought into existence in a social process of problem creation. In this process, many actors with different views and expectations play a central part.

There are many different facts about various things. Alone, a fact does not have much meaning. It gains meaning and social significance through interpretation. Interpretation is a process of putting facts into a context and organizing them into combinations or systems of facts. A system of facts which we don't like, which we see as "bad", is called a problem. Problem means several things: It means that we dislike the system of facts; that we want to do something to change the facts - "solve the problem or cure it" - and we want to do it now; action has a high priority. This is how a problem is created.

For example, it may be a fact that 63% of the people who live in Oakland are under 60 years of age; another fact about these

people might be that 40% of them have family incomes of $15,000 or more per year. And it may be a fact that 84% of them live in "good quality" housing. We might look at these facts and conclude that most of the people in Oakland are doing pretty well. Or we might conclude that some of the people in Oakland are not doing too well - some may be poor, some -- the same people or others -- live in substandard housing, and some of the people are over 60 years old.

We might conclude from these three facts that "Oakland has problems"; that Oakland does not have problems; that some people living in Oakland have no problems; that some people living in Oakland do have problems; that some people living in Oakland are old, poor and poorly housed, etc. We give the facts meaning by our interpretation. We transform the facts into problems. We say we don't like it when some people are poor or are poorly housed. A fact is only what is; not what is bad or what should be.

If you accept that people can interpret the same facts differently and can create different problems using the same facts, then we can look at a second critical step in problem definition. Where do these so-called facts come to use?

B. FACTS: THEIR DISCOVERY

There are different ways to "discover" facts, different methodologies. People in the university and in the community often use different ways to learn facts or "collect" facts. Often, those in the University won't accept the methods to learn facts used by people in the community; and often, community people will not accept the methodology used in the University.

If there is no agreement on what is a "real fact", on how to learn real facts and on the interpretation of facts, the meaning of the facts, there can be little agreement on what problems exist, there can be little agreement on who will or should do what about these problems.

If problem solution is preformed by problem definition, and joint problem solution is an interface goal, then the social process of joint problem definition is critical for the interface. Without commonality at this point, the University and the Community will rarely be able to "solve" anything to its own satisfaction and that of the other. The interface, then, begins at the point where facts are brought and discussed and jointly interpreted as problems. Once a common acceptance of a problem is achieved, strategies for "solution" can be sought. Problem definition is, in short, a social process of negotiation. When this negotiation occurs, there is an interface.

C. RESEARCH: A PROBLEM WORD

There is another word which creates confusion because of the different meanings given to it. The word is research. We said that different people use different methods of learning facts. Another way to say the same thing is to say that different people use different research methods.

One point to consider is that the more similar the research method, the more likely it will be that the same or similar facts will be "discovered." There is still little acceptance by people in the university and in the community of the research methods used by the other.

Second, the word research itself is a bugabo which causes, because of the different interpretations given it, a major paradox: Many in the university will not act without facts learned from research. Many in the community -- and increasingly in the university too--see research a cop-out from action, from doing something.

D. ON KNOWING THE ANSWERS

If people in the University and in the Community can't agree on how to get facts, on what the facts mean, on what the problems are, there will be little agreement on how to "solve" the problems. There will be littie agreement on the necessary strategies, tactics or resources.

Imbedded in the idea of problem solution often are three implicit beliefs: (1) that those in the University know the answers or solutions; (2) that knowledge, theory or skill can solve these social problems; and (3) that people in the university are just holding-out from using their knowledge to solve problems because they are sick, crazy, stupid, bad, dirty or whatever. One of these beliefs is examined briefly.

Most of the so-called social problems discussed at the interface are not amenable to solution simply by the application of knowledge, theory or technology.

By definition, these social problems are the creation of people who define a situation or a system of facts as "bad". Thus, personal beliefs and personal values (or group beliefs and values) are a source of the problem. Changing values create the stuff out of which more problems are created. The more men believe that it is their right and their neighbors' to have safe, decent, reasonably priced housing or universal, free health care, the more there will be a discrepancy between existing housing and health service and what is thought to be "basic" or "necessary". This perceived discrepancy is seen as problematic and it itself becomes the source of another social problem. More and more situations are thought to be undesirable -- hunger, the treatment of American Indians, urban slums, etc. -- and the demands for change are outpacing the efforts at remedial change, let alone major structural

and preventive change. This is precisely why knowledge, theory and technology are, paradoxically, causes of the discrepancies more than they are tools of amelioration.

The solution of a "social problem" is not an ability or skill held by those in the University. It is not simply "they really don't know", it may be also that "they can't do." Part of the demystification of the University, then, must be focused on the limits of knowledge, theory and technology in social problem solution. Attention and expectations might properly and profitably be directed to the social and political institutions of our country.

The belief that the University or its members can "solve" social problems is myopic. The belief that the University "could if only it would" solve these is naive. Most often, it can't.

The expectations that the University can and should and will solve social problems or that it is responsible for the casualities of these problems is a source of much acrimony expressed at the Interface. One task at the interface is to demystify the University and to learn about the Community. This is a first step in the process of interface - defining "realistic", i.e. valid expectations about the behavior and feelings of the participants.

This reality can result from bargaining among people, from joint negotiation. The Interface is in part this negotiation.

IV. TOWARDS DEMYSTIFYING THE SERVICE WHICH THE UNIVERSITY CAN GIVE TO THE COMMUNITY

The creation of an interface is the creation, recognition and acceptance of common expectations held by those in the University and in the community. One focus of these expectations is on what the University might give to the community. These expectations are often found in the view of the University as a service station.

The University is a place of scholarship and education. Increasingly, these are put to the support of service to those outside the University's walls. This service may be direct, as when the University pays for and/or administers a health clinic in a neighborhood; or indirect as when the university buildings are used as meeting places for neighborhood groups. The following brief discussion of these direct and indirect services is intended to suggest categories for organizing this subject as well as ideas to fill them.

The distinction between direct and indirect services is not to be confused with the distinction between the University as a corporate entity and the university as its members -- the faculty, students and administrators. There can be both types of service for either the corporate or member conception of the University.

1. POTENTIAL RESOURCES IN THE UNIVERSITY: THE NEED TO DEMYSTIFY THESE

The elements of both direct and indirect service are people, their knowledge, and space and money. These are the potential resources at hand in the University. The University's major resource is trained people, their ideas, expertise and, hopefully, their commitment. Second, the University has physical space, facilities and equipment. Last, the University has financial resources, and personal and organizational linkages to many people and organizations. All of these potential resources are elements of scholarship, education and service. Each must be the subject of demystification if the expectations held in the university and in the community are to facilitate the interface.

In one sense, scholarship and education are demystifying processes. They are the ordered search for and the transmission of facts and "truths". Often, these facts and "truths" are contrary to "common-knowledge". Conflict occurs frequently when these two "truths" or two facts are compared publicly.

In a similar way, the very process of scholarship and education must be the focus of demystification, for if they are not understood, many would continue to hold inaccurate expectations of their potential worth in problem solution and in service. One example of an invalid expectation already discussed is that the University could solve social problems if only it chose to do so.

There appears to be no consistent effort on the part of the University as an entity or by individuals within it to communicate, on a level appropriate to different people, what in fact goes on within a university, in its classrooms and laboratories. To demystify is not to devalue.

A second set of potential resources must also be demystified. It includes the University's financial resources and its "power" in the form of inter-personal and inter-organizational linkages.

2. THE UNIVERSITY IS RICH

Currently, most universities simply do not have nor can they get enough money to meet their current operating costs. For our purpose, note only that service is one of the three major functions of the university, and to most within it, not the most important.

This low priority is reflected in intra-university decision-making on the allocation of funds. Related to the amount of money available for service is the fact that most grant-money to the university is "ear-marked" for a particular purpose by the funding-source. Further, most designated funds are budgeted on a line-item basis, not on a lump-sum basis. The former is a barrier to the "flexible" use of funds. Last, most funds for the university are designated for research and teaching, not for service.

Were the financial status of and funding process in the University and its units demystified, Community expectations of the University could be more valid. Most important, those who want service from the University could choose other, appropriate organizations as targets to pressure; for example the funding resources of the University itself.

3. THE UNIVERSITY IS POWERFUL

The University's power in its actual and symbolic form must also be a focus of demystification. Many, especially in low-income communities, overestimate the power of the University or its members in the day-to-day affairs of the city or country; many overestimate the ability of the University to effectively challenge existing slum-housing, narcotics pushing, environmental pollution, and similar patterns of social organization. To demystify power requires a more delicate operation, for one source of power lies in the viewer's eyes. Here, demystification could lead to impotence.

4. THE UNIVERSITY IS A PROVIDER OF DIRECT AND INDIRECT SERVICES

Each of the potential resources of the University can be organized for either direct or indirect service. A basic policy decision to be decided in the university and then negotiated at the interface is: "What services should be in what form?" That is to say, what services should be administered and staffed with people on university salary?; what services should receive corporate sanction?; what effort should be made to administer services heretofore administered by public or private organizations?,etc.

Part of the answer to these questions lies in the word "service". The word "service" is central to the expectation that the University will "help the community". There are several meanings of service. First, the word is used to mean something like "actively making available and using

the resources of the University and its members for the purpose of working on issues of joint concern to people within the University and in the Community". In another, more limited usage, "service" means providing specific advice, treatment or intervention, for example dvice on designing a housing code, medical care for children in a specific neighborhood or testimony by a faculty person at an air pollution hearing held by a local voluntary association. Common to both uses of the word service are the notions of "making available" and "of giving, of providing".

In direct service, the University or its members have direct and major control over the service and directly do the service; in indirect service, each party has more equal control and the person who does the service is not on the University payroll.

5. TWO MODELS OF SERVICE

A. Urban extension

Urban extension is one model of a university-community service. It could include direct or indirect services, on either the general or on more specific levels. This model was created by analogy from the rural extension programs of the land-grant colleges. It has been tried under governmental and Ford Foundation auspices in several cities. In each, a different kind of urban extension model was tried. For example, at Rutgers University in New Jersey, seven goals were attempted:

1. Clearinghouse for data and sources of help
2. Counselor and Consultant
3. Convener of groups and individuals
4. Developer policy seminars and conferences
5. Provider of special education
6. Provider of general education
7. Developer of demonstration projects

This list suggests the variety of programs which can fit into any model.

B. UNIVERSITY AS A HUMAN SERVICE AGENCY - SURROGATE

A second, more limited model is the University as an agency-surrogate. Here, human services previously thought to be the responsibility of government or of private-sector organizations are administered by the University. A neighborhood health clinic is an example.

This is surely not an inclusive review of what has been done by different universities. Nor should it be, for the guiding principle in the provision of services can only be to create the interface; the model will be developed there.

PART TWO: THE DOMAIN OF HEALTH

INTRODUCTION

This introduction begins the second part of the paper. Here, the general discussion of part one is focused on the domain of health. The abstract issues reviewed above are specified here. The reader's task is also the same: To find what is acceptable, if not common, to those in the medical school, university-hospitals, schools of public health, of dentistry, of health related professions and to those in the community. As before, ideas, not solutions, are presented.

I. THE ELEMENTS = INTRODUCTION & DEFINITION

A. THE INTERFACE

The interface is those expectations of behavior held in common by those in the university and those outside of it on what each can offer the other, and on how they can "work together." Second, the interface is the act of working together; and third, it is the relationship which results from joint effort.

In health, these expectations are about direct medical treatment, rehabilitation of disorder or disability and the prevention of disease and disorder for an individual, for a large number of people similar in some way (population group), or for the social and physical environment. The expectations include questions of payment for these services, and how, where and by whom these services are delivered. These and similar expectations gain meaning when placed in a context of the University and the Community.

B. THE UNIVERSITY IN THE DOMAIN OF HEALTH

Education, scholarship and service in health are carried out in several places in the University. Education, the primary function of the professional health schools, usually includes schools of medicine, dentistry, nursing, public health, and, increasingly, a school of health related professions or para-professions. There are other health-related professional schools or departments: Psychology, social work, speech and hearing counselling, vocational counselling, for example. For teaching purposes primarily, there are adjunct clinics and hospitals. For example: A university-hospital, an eye and ear hospital, a psychiatric hospital, a dental clinic. Scholarship and research is carried out by staff and students in all schools and departments, hospitals, and clinics on patients who come there; on people living in communities near the University, and on the environment. Within the health-complex of the University, service follows education and scholarship; service is primarily for teaching and research. This is the priority in the University; it is often in conflict with the priorities held by those in the community.

C. THE COMMUNITY: WHAT DOES IT MEAN IN THE HEALTH FIELD

The word community appears in several terms in the health field: The community as patient; community health; community health services; community of solution; community medicine. All but the last term appear in a report of the National Commission on Community Health Services entitled Health Is A Community Affair. It is now common to hear in the health field cries for "community control" and community participation, and discussions of community organization.

"Co[illegible] is increasingly an ideological word in the sense that when people hear the word in certain phrases their feelings are

stirred. Like a flag in war, the meaning of the word, if you will, "excites" some people. In this sense, the word community potentiates the emotional response some people have when they hear certain phrases. The word community has become a symbol of certain ideas. As a symbol, it is part of political rhetoric and political dialogue.

Once we recognize that words like community, neighborhood, citizen, and consumer MIGHT be used ideologically (as well as descriptively and analytically) we can begin to sort out some of what is meant and some of what is heard when the word is used at the interface. Some examples of phrases used in current medical and health discussion are discussed very briefly.

1. "The community as patient" is a public health aphorism. Unfortunately, it is misleading and in current public debate it has a connection many wish to avoid. The phrase is misleading because, as was shown, the word community can mean people, place, voluntary associations or an ideology. Which of these is the patient?

2. Community health is also a vague term. It implies that a health or illness status for a population group has been defined. Yet, the elements of this status are infrequently noted and, even more rarely, discussed. Moreover, and this is discussed below, community health (status) is built on the notion of "need" - another loose word.

3. Community medicine means providing individual health service in a community to people living there. Most often, the people are poor. Other distinctions between these terms could be made, but they would be "academic." The major purposes of presenting this limited discussion were realized.

It was shown that the word community is used frequently in the health field and that the word is "in". As a consequence of its potentiating effect on the listener, that is, its ideological function, many sloppy and dubious proposals have been accepted. The creation of an interface, however, depends on a clear idea of what the word community means and how it is used often to "mobilize the emotions."

D. COMMUNITY: SOME OTHER CURRENT USES

1. The word community in the health field has come to be a shorthand term for poor, "minority group" people like poor Blacks or Chicanos. This shift in meaning follows a debate, increasingly public, about the effectiveness, efficienty and costs of health care in America. One topic in that debate is the relation between poverty and health. This relation is summarized in the phrase, "The poor are sick and the sick are poor. Without help, the sick get poorer and the poor get sicker."

The shorthand use of the word community should not blur the fact that non-poor live in the community and they too frequently receive health care which is ineffective, inefficient and expensive. The services for the poor are worse in most respects but, and this is critical, the whole social institution of health is under public scrutiny and attack. This includes private practitioners in medicine, the hospitals and clinics, and public health departments. The university-related health complex is both part of the target and, to some, part of the solution.

2. Community participation is a phrase in current use in the health field. It means that people living in a given area want to participate in these decision-making processes in which they think or feel they have a stake. In political terms, clients of specific agencies

or people who are otherwise non-elites want to participate in those decision-making processes heretofore limited to elites. They want "in" on "who gets what, where, when or how", the ubiquitous political questions. This is the essential meaning of the phrase "community participation"; and of the related phrases "citizen or consumer participation" and "citizen or community involvement". In the health field, citizen and community have other, newer meanings.

3. Recently, these concepts have come to mean member of a voluntary association, part of the organized community.

Another new meaning is "lay", as in not-expert or not-professional. In this usage, a layman is a non-elite, someone or some group without power or control over certain decision-making processes. "Community control", then, is a phrase which means that non-elites want elite positions in these decision processes.

Such emphasis is placed on these meanings because the interface in health will be devoted largely to issues of "who makes or controls what decisions about which health services in which place, when and how".

II. TOWARDS THE INTERFACE IN THE DOMAIN OF HEALTH

A. VIEWS OF THE COMMUNITY HELD BY MANY IN THE HEALTH PART OF THE UNIVERSITY

1. The Foreign Affairs Model in the Health Domain

In the foreign affairs model, the community is an underdeveloped or developing area. In international affairs, health services have been a major focus of inter-national effort, and a means to developing on-going diplomatic relations among nations. In a socio-economic sense, health,

and environmental problems have been a major barrier to national socio-economic growth. Medical, health and environmental services have been a major source of social change. Overseas, ours is Western Medicine; in the ghettos and on the Reservations, it is White Man's medicine. The foreign affairs model is useful here at home, for understanding a major difference between the University and the Community in the domain of health.

There are many cultures: The medical and the lay; the professional and the lay; the academic and the professional; one profession and another; the University's and the Community's. Clearly, there are cultural differences between "us and them," between the practices of health professionals, their organizations and the people served. The foreign affairs model forces the recognition of these different cultures and the consequences of these differences.

One consequence is the different priorities assigned to different health and environmental problems by professionals and by those living in the community. Another consequence is the differential evaluation of how, where and when specific services are or should be given. A third consequence is the professional's propensity to assign or impute negative attributes to those laymen who do not follow his advice. The title of a recent book is illustrative: Public Health For Reluctant Communities.

There are cultural differences between the health worker in the University and the patient. These cultural factors vary by training, income, ethnicity and place. The foreign affairs model forces their recognition.

The model also offers a way to raise the issue of racism in health problem definition, service, scholarship and education. A majority of professional health workers are white and a probable majority of hospital workers are non-white. With the increase in racial selfawareness and it's sociopolitical-action consequences, unions have successfully organized in University-affiliated hospitals. Unionization has resulted in a greater delineation of the tasks performed in the hospital. The racial distribution of hospital staff by task performance now shows clearly, many if not most of the "menial" tasks are performed by non-whites. The issues of professional non-professional task allocation is thus highlighted by the addition of race as an issue. The resultant breakdown is professional-white and non-professional-non-white. The apparent in-hospital staff "harmony" which was thought to characterize staff inter-personal relations is now seen as a myth.

As a consequence, there are two "nations" within many university-affiliated hospitals. We have yet to see the consequences of this racial separation, though one could imagine a community group like the Young Lords in New York City attempting to link-up with their "brothers" in an effort to "liberate" a local, university-affiliated health facility. The New York Times has recently had a suggestive series on this.

2. THE COMMUNITY AS A LABORATORY

Another view held by many in the university is that the Community is a laboratory for public health and medical training, and research. The phrase "he is practicing medicine" points up the different perception of the laboratory model by those in the university and in the

community. The former use the phrase to mean "giving service;" the latter understand it to mean "training on us."

One purpose of research is to develop scientific theories about disease entities and the etiology of non-disease disorders of man and his environment like automobile accidents and air pollution. When theories are substantiated, primary prevention of disease and disorders are possible.

As University-Community relations have become strained, staff and students find in-community work more difficult, though students more often ask for it and faculty more often think it necessary. One response by university people to these "hostile" groups -- in most cases Black, Chicano or Puerto Rican - is to promise some "pay off" to individuals or groups from the research and "field work."

Too often these promises can not be met. This is especially true of research on mental health, mental retardation, drug addiction, alcoholism and other complex diseases or disorders. Research of this kind rarely has a direct service "pay off" for the individual or the Community in terms which he understands or, more important, he accepts.

B. SOME VIEWS OF THE HEALTH PART OF THE UNIVERSITY HELD BY MANY IN THE COMMUNITY

Because of the condition of our national health system, or non-system, many of every social class and race see the university-affiliated health complex as a potential source of service for themselves, and as an ally in the effort to create a viable local and national health service system, i.e., to create services which are accessible, effective, efficient and reasonably priced. This national problem is most visible on the local level. There, social action efforts supported by the ideology of Localism are directed at creating "comprehensive, responsive, responsible, effective, efficient, low-cost service" - surely no simple

In this social action effort, those who do not actively support the attempt to get the University-affiliated health centers to become a primary source of medical treatment are seen as "enemies", the reasons for their opposition notwithstanding. In other words, the university-related health centers are being asked to become surrogate municipal or what used to be charity hospitals by offering treatment to whomever needs or wants it regardless of his ability to pay. This is a clear request by many ethnic and racial groups, especially those composed of poor people. The middle-class requests are somewhat different. But many in both social classes do not understand and/or accept that the patients accepted for treatment in a university-affiliated hospital are there for either their "teaching value" - as in an esoteric case - or because of the severity of their condition. This is so because these medical centers most often are well-equipped and have highly trained staff.

Many people do not understand the priorities of the hospital, do not understand its relation to the purposes of the University and of the medical school. Instead, they see a physical facility, usually with a good reputation, closed to most of them. If they are poor, they are asked to go or are forced to go to a usually more crowded, older, less effective (in their eyes) municipal or charity hospital. Given their position, what can they conclude?

The middle-class hold somewhat different expectations of the university health center. These people want to retain the private practioner. Thus, their demands on the university are different.

The middle-class does not seem ready yet to do away with direct personal payment for treatment. There are several reasons for this beyond the often latent belief that in medical care, personal payment enhances

personal control over the practitioner and over the quality of the care. The belief that government payment would result in the loss of "the freedom to choose" is surely related too. What these community people want is access to the emergency room and to the specialized staff and equipment thought to be in the university hospital.

The changing structure of medical treatment and the consequent change in the role of that culture-hero - the personal, family doctor has resulted often in the use of the emergency room as a middle class clinic. Technological advances in medical care, and the publicity about these, have focused on the role of the medical school and university-hospital as a center of treatment research. Many of the technological advances have resulted, in turn, in treatments for relatively rare disease and disorders. The laymen, however, has come to believe that any place which has people who can do heart transplants and other relatively esoteric procedures must be good; indeed, must be the best place to get treatment for any disease or disorder. Consequently, the health conscious middle-class want to retain the scholarship, i.e., research, function of the university affiliated health center. This emphasis could result in a relative scarcity of services and lower priority for services.

Many factors beyond social class and health services utilization patterns must be considered in the policy questions suggested by this discussion. All of these will surely emerge again at the interface.

Note again the dysfunctional consequences of oversell, and how the failure to demystify and the failure of professionals to clarify what they have in fact to offer have resulted in ambiguous and overlapping expectations of the University health center.

III. SOME CONSEQUENCES OF THESE DIFFERENT VIEWS AND EXPECTATIONS

A. THE DIFFERENCE BETWEEN NEEDS AND WANTS

In the context of the relation between the University health complex and the Community, the major public issue is the differential expectation held by each for University-affiliated medical care. The University sees the provision of medical care to people in the community as one minor responsibility proceeded in priority by education and scholarship. Individuals and groups in the community want medical care to be the University's first priority. They define services as a responsibility of the University and, further, they argue that they have a right to this service.

To better understand this crucial issue, one must distinguish between two key words - wants and needs.

In this paper, a want means a stated request by someone or some group for something. A need is someone's judgement that another person (or group or class of people) is deficient in some particular way.

Related to wants and needs is the idea of "having a right to something." Let us look briefly at how these three words and ideas are related often in discussions of services.

When I say (or we say) that I want you to provide a particular service that I can then choose to use, I may be saying several things:

(1) I desire this service.
(2) I demand this service.
(3) I have a right to this service.
(4) I "need" this service.
(5) I believe that it is your responsibility to provide this service for me (or to me).
(6) I should have this service. etc.

Each one of these phrases is somewhat similar. Yet, each is somewhat different too, and it may be the difference that is critical. Each phrase can be heard to mean something different; and each phrase is legitimated by reference to different values and "principles." As Minoque notes (in the Liberal Mind)

> A need is an imperative form of desire. 'I desire bread' imposes no serious demand on anyone. 'I need bread' does impose such a demand. We may be justified in denying children, for example, what they desire, but we are not justified in denying them what they need. A need, therefore, is a legitimate or morally sanctioned demand.

It seems that in the past, rights and needs were related while now rights and wants and rights and demands are related. To connect this now to the topic of services.

Health services and medical care in particular used to be allocated on the basis of "need", that is, to the casualities or to those at high risk to disease or disorder. When "medical need" was present, a second level of "need" was introduced - economic. Government-administered direct personal care and government-supported direct personal care were available to the "sick who were poor". This is the so-called charity medicine still available in municipal, state or federal facilities depending on the person's health needs, his economic needs and other "eligibility". As "needs" have become "rights", demands are phased in the vocabulary of "rights". These demands have focused on changing, e.g., broadening, the requirements for "eligibility" and thus reducing the scarcity of these human services. Demands which were heretofore focused on government are, in part, now focused on the University. These demands appear as the right to have available to use

and the right to in fact use university-affiliated medical treatment. This transformation of needs into rights is reflected in another area of health.

ON NEEDS

One focus of university sponsored health research has been the determination of a "community's health needs". Another is the ranking of different communities on the basis of these needs. Related is the use of the concept need in the professional-patient or "community" relationship. Last is the use of the word need as a measure of the ratio of health workers and health services per size of the "community". Each is commented on briefly in the belief that the concept of need in its various meanings has profound consequences for an interface in the domain of health. It is a main source of difference between those in the University and those in the Community.

In the domain of health, discussion and negotiation is not among equals, it is among professionals and laymen, professional and citizens or among physicians and potential patients. The concept need, in its various professional meanings in medicine, public health and psychiatry, has the function -- although not necessarily the conscious intent -- of prohibiting non-professionals from discussing and bargaining with professionals. As a consequence, non-professionals and non-elites require other sources of moral, legal, socio-political legitimation for their demands. This is the legitimation of demands as rights. How the concept need preserves this hierarchy is seen in each of the four uses of the term noted.

The word need in the health field is used to mean that, "I, as a professional, can determine the difference between your condition and some ideal or real standard of 'health'." This usage is built on the

idea that such standards exist, have validity and legitimacy within the profession. Research on "community health needs", thus, is an attempt to place a given population-group called a "community" on a scale relative to a set of standards. To discuss health needs, then is to talk about people as individuals - he is healthy or not healthy or relatively healthy - or as population groups: Taken together, collectively, they have an average health status of x relative to some standard. Thus, communities are judged and ranked and the resultant findings are called the "community health needs". Since professionals define the standards and control the means of study, i.e., diagnosis, only they can determine the needs. This is one acceptable, legitimate social function of a profession. In this framework, "what I want or what we want" has less validity in public debate than what the professional says I need or we need. This judgement on the health status of a population group relates directly to recommendations on the amount, kind and quality of services which these people need.

The determination of a "community's service needs" is made in a similar social process. Here the standard is an explicit or, more often, implicit ratio of numbers of practitioners to numbers of people of a certain health status. This ratio can be expressed in the form: "one physician per 6,000 potential patients" or in some similar way. Note again that the demand for "more doctors" has validity to professionals only when compared to this standard.

It should be clear now that the concept need is critically important at the interface. It is an element in all attempts at "health planning:, and in all discussions of "citizen, consumer or community participation."

A parenthetical, though interesting idea, is that the concept need functions in the internal logic of medicine, health, and mental health like the concept "false consciousness" functions in classical Marxist thought. It is used to "devalue", to negate, to explain away one's opposition. Since neither needs nor false consciousness can be observed, it is used by imputation of the professional or "true" Marxist. The consequence of both uses is the same: He who is the true believer or the expert remains so. Discussion at the interface is rife with this form of the ad hominem argument, and, consequently, professionals become barriers to discussion and negotiation. Often, to paraphrase a current saying, "those who are the solution may also be the problem".

The purpose of this brief discussion of services, needs, wants and demands was to suggest first that there may be confusion at the interface about what community groups are asking of the University and what the University will or will not offer, can or can not offer, does or does not provide.

A second purpose was to suggest that these words may be clues to the kind of legitimation sought by groups and by the University for their positions. Clearly, certain kinds of legitimation enhance the probability of achieving one's goals.

Third, we suggested that bargaining in the domain of health is difficult for non-elite, i.e., non-health professionals, because the power to decide issues is administrative and technical and professional. Community groups have only their wants, demands or needs for service. These moral and political legitimations may not be enough.

One consequence of this discussion could be heightened awareness of how these words produce political conflict at the interface. Without clarity and understanding of who is bargaining for what, how, the chances of winning are limited.

IV. PROBLEMS: THEIR DEFINITION AND SOLUTION - E.G. ENVIRONMENTAL POLLUTION

It was suggested in the first part of this paper that social problems are "man made", that they are "created" in a social process of labeling. Implicit in that discussion was the idea that part of the interface was the task of using knowledge discovered in the University to focus public attention on facts and situations which are considered problematic, i.e., for "creating" new social problems. The environmental, ecological "crisis" is a recent example of how this process works in the domain of health.

Dennis F. Miller has written in a recent issue of the University of Chicago Magazine:

> The idea of pollution is not new in America. Conservationists and ecologists have been warning the nation of the inherent dangers of the gradual poisoning of the environment for years. But the widespread interest by the public in all aspects of pollution is a relative recent phenomenon. People at all levels of society have begun to be wholly aware of the connection between the heavy pollution around them...and the dangers to their health and that of their children born and unborn.

To paraphrase, the facts were known and viewed as "bad", as a "problem". But this "problem" did not receive broad public legitimation until recently. It was seen as a problem to those few professionals in that field, to related voluntary associations like the Sierra Club and the National Wildlife Federation and the professional groups like the American Public Health Association. Recently and dramatically, environmental pollution has become a broad-based social problem. Many new groups and individuals throughout the country are "working on it".

University schools of public health have been a major source of research in these areas, yet their effort is both little known to the community and often it is little appreciated.

Many see the whole environmental issue as a way to avoid acting on "more pressing" concerns of theirs. By extension, many of these people see the University's efforts in pollution, as a "cop out", for they want medical treatment for the Community to be the first priority of the University-related health complex. These different constituencies of the University in the domain of health, then, hold different expectations of the health complex and different priorities for each part of the health center. The issue of environmental pollution is "real" and surely worth your time to discuss. It is raised here as a means to bring before you other areas of University-related health activity.

V. NEW SOCIAL PROBLEMS

The problem of environmental pollution allows the discussion of an issue which also belongs at the interface: The relation between university-research on social problems, social action to prevent or ameliorate the social problem, and political power. Reference was made to these relations in the discussion of beliefs held by many in the community on the political power of the University.

The domain of health includes the personal medical care system with its practitioners and patients, and the field of public health -- health services for population groups, and social efforts to maintain a "healthy" environment. As our concern shifts from the medical care of an individual to the status of the "environment", the focus of prevention and remedial action shifts to larger social organizations and social institutions. These larger entities tend to be "more central, more basic"

units in the country. the more powerful ones. Action to change the configurations of social and political power on these levels is surely "radical". The prevention of environmental pollution will require changes in the political structure of this country, in the relation between government and industry, and between political and economic beliefs. These changes may come about, as in the past, through incremental social change. Thus, we participate in groups with a political and social philosophy supportive of limited actions on prescribed issues. But these limited actions on prescribed issues are somewhat ineffective vis a vis problems like environmental pollution and "overpopulation". To prevent or ameliorate these social problems, effort must be directed at institutional power and decision-making in government, in industry and in the relation between these. It is on these socio-political issues that the University could find its Waterloo. Political "neutrality" on these issues is "impossible". Inaction is viewed as complicity with those who are doing "wrong" and as action in defense of the status quo. Findings from research done in the University on these social problems will be viewed through the glasses of socio-political beliefs. The boundary between scientific or technological face and the socio-political use of these facts will blur. These are the issues and foci of the seventies, of the Movement. These are some of the issues of the University and its constituents in the community in the health domain. Unfortunately, "selective inattention" too often precludes discussion of these. An example follows:

Bill Kovach wrote a recent New York Times article on Calumet Community Congress, a new community group in Gary, Indiana which is composed of over 150 other community groups of "widely different social

and political colorations..." The purpose of the new group is "to bring pressure on the giant steel mills to end pollution and on political organizations which have controlled Gary for years". (My emphasis.) (December 7, 1970, p.33) Several U.S. Senators publicly supported the new group as did consumer advocate Ralph Nader. Observers were present from Baltimore, Newark, Providence, Chicago, Cleveland, Detroit and Philadelphia. The Congress organizers were trained at Saul Alinsky's Industrial Areas Foundation Training Institute, Chicago. It is with new community groups like this one that the University's relation to the Community will be tested, for the different constituencies of the University will hold incompatible expectations of University action. Each of these expectations will be a stress which will appear at the interface.

VI. FINAL NOTES ON SOME DIFFERENCES BETWEEN THE UNIVERSITY AND THE COMMUNITY

The differences between the University and the Community are those related to the priorities for University service to people in the community; to the focus of social change desired in the health sphere within the University and beyond it; to the strategy and tactics of these actions; to the use of knowledge and professionalism as sources of power and thus of control over disease processes and social processes and people; to the bureaucratization of health services and to the control of these bureaucracies by professionals, faculty or "the community"; to the specification of decision-making domains in which groups outside the University can participate in making decisions which were heretofore made largely by those within the University; to the differential definitions of what health services are needed and wanted; to the social

organization of these. These are scientific, technological, political, ethical and moral issues with high symbolic and emotive meaning. That is why the debates of the seventies will be complex and acrimonious, One task is to make explicit those "inarticulate premises of action". As Lamartine has written:

> These times are times of chaos; opinions are a scramble, parties are a jumble; the language of new ideas has not been created; nothing is more difficult than to give a good definition of one's self in religion, in philosophy, in politics. One feels, one knows, one lives, and at need, one dies for one's cause, but one cannot name it. It is the problem at this time to clarify things and men...The world has jumbled its catalogue.

VII. WHAT EACH PARTY HAS TO OFFER AT THE INTERFACE

A. WHAT THE UNIVERSITY HAS TO OFFER

In the domain of health, the University can offer scholarship, education and service. The content, the form and the quality of these will be determined at the interface. Some suggestions are made in this proem.

1. Scholarship - What are some of the issues?

The focus of university scholarship in the domain of health is determined by factors like the researcher's interest and competence, financial support available, peer judgements on the "value" of a given subject, considerations of the "utilitarian worth" -- the size and kind of potential benefits to "Man" -- which might result, among others. For each scholar, the factors determining the choice of subject to study will differ. This is necessary and acceptable. The University, however, may be pressured by its constituents to take a stand by developing "guidelines" and priorities in research. This is one possible consequence of the severe cut-backs in federal money for research in the health domain. A change in federal policy on medical and health research

could also push the University in this direction. An example of a policy change now beginning apparently is the switch from "project grants" to university-affiliated researchers to federal "contracts" made with the scholar and his department. If the University is pressured, so too will its members feel the pressure. Pressure will also come from different groups in the community, each asking or demanding University accountability for the actions of university-based researchers; and each asking and demanding a role in the decision-making process which will determine university-wide policy on research. These are but a few of the socio-political issues which could arise in discussion of university-based scholarship at the interface.

More specifically, emphasis will probably be placed on the content of medical and health research. One can anticipate research on the delivery of medical and health services rather than on new treatments for specific diseases. Such studies might focus on the evaluation of existing care and existing patterns of delivery. Such research would dovetail with the evaluations of existing services being made by many recipients and groups of recipients. It would bring to bear the resources of the University for the "benefit" of the Community.

On the other hand, applied research and scholarship could too easily come under the heavy-handed influence of its sponsors or of a politically powerful community group. Buried in the issues here are intensely discussed questions: the role of the researcher working for an organization, his claims to "objectivity", and the counter-claims of his partisanship. The researcher studying social problems in the health domain will be open to pressure from many sides, more so as his work becomes demystified, his methods and findings become open to scrutiny by a public with values different from his, and claims are

made on his freedom to choose his own subject for study. The pressure to be "socially relevant", to work for "the general welfare" can be extreme, however apparently noble "the Cause".

These are interface issues, and debate on them is expected to replace the current deification of medical research. Open and active debate can rarely take place in an atmosphere built upon faith and symbols alone. Medical and health research itself can be evaluated. And the self-conscious process of scholarship is one means to do this.

2. Education

The recent report of the Carnegie Commission on Higher Education in medicine and dentistry helps create a social atmosphere in which occur interface discussion on what the University as a teaching institution can offer the community. In the health complex, these discussions could consider the amount and kind of education necessary to perform a job in the health system. An important subject is the "kind of person" who can be recruited, trained and employed. Here, race, social class and previous education are central issues.

The University is a "societal gate-keeper" - a grantor of credentials in a society obsessed with this means of people zoning. These credentials, i.e., degrees, largely determine one's economic, social and health life chances, one's opportunities. Because of this credential granting power, the University can offer individuals and groups means of gaining power too. This is an interface issue in the global way it is presented here and in the specifics of accreditation, academic and professional standards and the other myriad topics involved.

B. Service

What "service" can the University offer the Community, and what will different community groups accept? These are central questions in the domains of personal medical care and public health. Should the University-affiliated medical school and hospitals become the axis of the community's medical treatment system?

In public health, direct care to the people is infrequent. This must be made categorically clear to community groups and to the public at large. Failure to do so can only lead to continual negotiation for these services, negotiation based on invalid expectations.

The University might provide service, however, in two areas: Research and teaching. In practice in the fields of medicine and public health, service in these areas could result in several kinds of consultation to organized groups and to organizations in the public and private sector. Such consultation could be on "how to do research", how to document "felt need" or wants for medical or health service; how to evaluate an on-going health service; how to organize a health education or health action program. (The latter is obviously a more potentially politically-explosive task.) The consultant would bring the "best" the University has to offer--the knowledge of its members.

To ask the University to commit its corporate name to something more, however "good" the partisan cause, might be to endanger its political existence, and, in consequence, its unique role within society. This issue is critical; hopefully it will be before your every comment.

The pressures to support "good, humanitarian, Liberal, etc." causes are real, potent and unceasing. These are felt by students, faculty and administrators. The impulse to act is great, regardless of

motive or socio-political philosophy--yet to act without considering the potential consequences--including those that might be dysfunctional at a later point--is folly. Henri Bergson's famous quote is truly applicable here: "Act as men of thought; think as men of action."

Beyond sending consultants out into the Community--to answer a request or to stimulate a request--the University might make other clear commitments congruent to its social roles in education and research. For example, it could be the setting in which demonstrations of innovative treatment practices could be developed and given public exposure so that local groups could learn about these. These groups can then use this knowledge to pressure other service deliveries to adopt the innovation. This is one form of "community education".

Another form could be the education of individuals and groups on matters heretofore within the province of "professional expertise". This includes the issues of "standards of service", what these are, how they are developed, how they are enforced, and by whom; it includes education on the tasks performed by medical and health practitioners and the professional rationale of the education necessary to perform each. These rationales at some point might be shown to be invalid; in short, the University could educate individuals and groups on the inner workings of the medical and health system. In this way, it could help to demystify these.

Clearly, providing opportunities for education in the medical and health field is a major service to the Community. Other services will emerge at the interface, for that is one of its reasons for being. The interface in health is that process of joint exploring and bargaining and deciding about service, scholarship and education.

B. WHAT THE COMMUNITY HAS TO OFFER

Individuals and groups in the community can offer themselves first and foremost. As thinking, feeling people, they must make their needs and wants known. This is not a shibboleth; it is a moral and socio-political imperative, for without the direct and constant presentation of their views, the University can too easily ignore their presence, can too easily become the sole voice of wisdom about "the people". It is apparent that at a time of vociferous and visible University-Community conflict, many of "the people" are quiet and invisible. Have the people become pacified?; or has futility replaced anger, self-respect and the politically and psychically "healthy" act of demanding what one feels is his right?

Second, the people can offer their ears and listen, for without learning about medical and health practice they can only defeat their ends. This knowledge will help them get what they want. And it will help them learn that what they have is too often poor. Alexis de Tocqueville put this point well:

> The evil which was suffered patiently as inevitable seems unendurable as soon as the idea of escaping it crosses men's minds. All the abuses then removed call attention to those that remain, and they now appear more galling. The evil, it is true, has become less, but sensibility to it has become more acute.

Third, the people can offer their own research findings, however different the research methodology they used. They can offer to educate the academicians and the professionals to who they are, to what they believe, to how they live and to what they want.

IN CLOSING

Those in the University and in the Community have much in common. Often this is in the abstract like broad goals and broad values. It is in the concrete, the specific goal and specific means that differences appear. These differences in perception, cognition, attitude, etc., become barriers to common cause. These differences will be the stuff of discussion, negotiation and conflict in the seventies. To paraphrase sociologist, Robert Merton, we are living in a "context of distrust" and we "no longer inquire into the content of beliefs, assertations to determine whether they are valid or not". We in the University and in the community, we who are rational are together guilty of shrillness in our discourse, of a poorly articulated and somewhat frenzied anger and despair.

The task before you is clear, although the means to accomplish it are not yet fixed. At worst, try to reach an interface "authentically"--in Sartre's words--with "a true and lucid consciousness of the situation, in assuming the responsibilities and risks that it involves, in accepting it in pride or humiliation, sometimes in horror and hate."

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